Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PETER G FOOX MD
PO BOX 8795
TYLER TX 75711

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-13-1363-01

MFDR Date Received
JANUARY 31, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "1. Routine office visit = not paid despite 2 attempts – denied. 2. EMG/NCV studies were preauthorized with #072702801 – yet unable to secure payment. It should be noted they have approved additional surgery with Dr. Azouz – proving that this is a valid claim."

Amount in Dispute: $971.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 3, 2012	CPT Code 99213-25	$123.00	$107.86
	CPT Code 95903-59 (X2)	$350.00	$226.48
	CPT Code 95904-59 (X4)	$192.00	$192.00
	CPT Code 95860 (X1)	$360.00	$145.49
TOTAL		$971.00	$671.83

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the

reimbursement guidelines for the disputed service.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 133-The disposition of this claim/service is pending further review.
   - X727-Claim is being disputed, therefore no payment is being made at this time.
   - Z656-Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.

Issues

1. Does a extent of injury issue exist ?
2. Is the requestor entitled to reimbursement for CPT codes 99213-25, 95903-59, 95904-59 and 95860?

Findings

1. A review of the submitted explanation of benefits finds that the respondent denied payment based upon reason code "X727."

   The May 11, 2012 Contested Case Hearing decision found that "The compensable injury of April 19, 2010, does not extend to and include post-traumatic osteoarthritis of the left shoulder." The compensable injury of April 19, 2010 is limited to a laceration/crush injury to the employee's left hand and right thumb.

   According to the submitted medical bill, the requestor billed the disputed services for the diagnosis 815.01-closed fracture of thumb.

   A review of the office visit report finds that the clinical examination was limited to the wrist and thumb; therefore, the respondent's denial is not supported and reimbursement is recommended.

2. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2012 DWC conversion factor for this service is 54.86.

   The Medicare Conversion Factor is 34.0376

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 75702, which is located in Tyler, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Rest of Texas.

   Using the above formula, the Division finds the following:

Code	Calculation for Locality Rest of Texas	Maximum Allowable Reimbursement/ Amount Sought by Requestor if Less	Respondent Paid	Due
99213	(54.86/34.0376) x $66.92 for 1 Unit	$107.86	$0.00	$107.86
95903	(54.86/34.0376) x $70.26 for 2 Units	$226.48	$0.00	$226.48
95904	(54.86/34.0376) x $52.79 for 4 Units	$192.00	$0.00	$192.00
95860	(54.86/34.0376) x $90.27 for 1 Unit	$145.49	$0.00	$145.49

TOTAL		$671.83	$0.00	$671.83

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due for the specified services. As a result, the amount ordered is $671.83.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $671.83 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/31/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.